Clear Form Print

Nebraska VR ABI Screen: Complete this screen if the client answered "Yes" or "Not sure" to the ABI question on their VR application.
Note: This screen can be completed at any time if you suspect or the client indicates they may have experienced an acquired brain injury (ABI).

Name: _____ Date: _____ VR Specialist: _____

Step 1. Prompt the client to think about **all incidents or illnesses** that may have occurred at any age, including those that they don't recall, but others may have told them about.

In your lifetime (including childhood) have you ever **injured your head, face or neck** (e.g. from shaking, car or other moving vehicle accident, fall, fight, gunshot, explosion, contact sports or military service, etc.)? ☐ Yes ☐ No

Injury #1: _____ Age _____ Were you hospitalized or treated in the ER? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____

Were you dazed or did you have a memory gap at the time of injury? ☐ Yes ☐ No If yes, for how long? _____

Injury #2: _____ Age _____ Were you hospitalized or treated in the ER? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____

Were you dazed or did you have a memory gap at the time of injury? ☐ Yes ☐ No If yes, for how long? _____

Repeated impacts to your head (from shaking, contact sports, military service, etc.)? ☐ Yes ☐ No Were you hospitalized or treated in the ER? ☐ Yes ☐ No

If yes, from approximately age _____ to age _____ Description: _____

In your lifetime (including childhood) have you ever experienced an illness or event that affected your brain (e.g. cancer, stroke, meningitis, West Nile virus, seizure disorder, tumor, drowning, poisoning, etc.)? ☐ Yes ☐ No

Illness/Event #1: _____ Age _____ Were you hospitalized or treated in the ER? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____

Were you dazed or did you have a memory gap at the time of injury? ☐ Yes ☐ No If yes, for how long? _____

Illness/Event #2: _____ Age _____ Were you hospitalized or treated in the ER? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? _____

Were you dazed or did you have a memory gap at the time of injury? ☐ Yes ☐ No If yes, for how long? _____

Step 2. Determine the functional impact of noted injury(s)/illness(s) or event(s) on the client's everyday functioning by completing the challenges checklist on Page 2 with the client.

In the time since the injury(s), illness(s) or event(s), how often…	Never	Seldom	Often	Depends	Comments
Do your memory problems interfere with getting things done on time?	☐	☐	☐	☐	
Do you get distracted and forget to finish a task?	☐	☐	☐	☐	
Do you struggle to remember what people have said to you?	☐	☐	☐	☐	
Do you repeat yourself because you don't remember what you told someone?	☐	☐	☐	☐	
Do you have difficulty staying organized or setting priorities?	☐	☐	☐	☐	
Do you have difficulty finding your notes or To Do Lists?	☐	☐	☐	☐	
Do you have difficulty estimating or managing time?	☐	☐	☐	☐	
Do you have difficulty keeping track of appointments?	☐	☐	☐	☐	
Do you feel exhausted or overwhelmed by your memory problems?	☐	☐	☐	☐	
Do you have difficulty finding documents or other information you need?	☐	☐	☐	☐	
Do you have difficulty getting ready for appointments or activities on time?	☐	☐	☐	☐	
Do you struggle to track completed tasks and those that still need to be done?	☐	☐	☐	☐	
Do you have difficulty completing multi-step tasks?	☐	☐	☐	☐	
Do you have difficulty following verbal (spoken) instructions?	☐	☐	☐	☐	
Do you have difficulty following written instructions?	☐	☐	☐	☐	
Do you have difficulty reading maps or understanding diagrams or charts?	☐	☐	☐	☐	
Do you feel stress trying to remember your assignments or plans for the day?	☐	☐	☐	☐	
Do you sense that your behavior or social skills cause you problems?	☐	☐	☐	☐	
Do you struggle to complete paperwork or steps to get the services you need?	☐	☐	☐	☐	
Do you struggle to make decisions, solve problems and have good judgment?	☐	☐	☐	☐	
Do you fear memory problems will make finding the job you want difficult?	☐	☐	☐	☐	
Do you have other concerns that are not listed?	☐	☐	☐	☐	

Comments/Observations:

_____

_____

Step 3. Discuss noted challenges with the client and determine if referral for Vocational Evaluation (include Perceptual Memory Task and VCWS 6 Independent Problem Solving) and/or Assistive Technology Evaluation are appropriate. Include a copy of the completed screen and challenges checklist with referral. See VR Program Manual, Employment Discussion Chapter for additional guidance.

Step 4. Give the client a *Nebraska Brain Injury Information, Referral and Resource Facilitation Services* brochure (download from VRIS) and ask if they would like assistance in contacting the Brain Injury Alliance of Nebraska for information and referral services.

Step 5. Email or fax the completed screen and challenges checklist to Keri Bennett, keri.bennett@nebraska.gov or (308) 865-5348.